9555 SW Barnes Road, Suite 255
Portland, Oregon 97225
503-908-1590

Membership Service Fees Recurring Payment Authorization Form

Membership Service Fees are automatically deducted from your checking or savings bank account, or charged to your Visa, MasterCard, American Express, or Discover Card. You authorize regularly scheduled charges to your checking/savings account or credit card **monthly.** ~~Y~~You will be charged the amount indicated below each billing period and a receipt for each payment will be made available to you. You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

PLEASE COMPLETE THE INFORMATION BELOW

I hereby authorize AIM Health to automatically withdrawal from my account, as indicated below, to pay for membership Service Fees.

Authorized Full Name:_____

Billing Address:_____ Phone:_____

City, State, Zip:_____ Email:_____

MEMBERSHIP TYPE AND PAYMENT

Payment Frequency:			
Ages 18-39	$50 per month	$150 per quarter	$570 per year
Ages 40-59	$60 per month	$180 per quarter	$684 per year
Ages 60+	$90 per month	$270 per quarter	$1,026 per year
	$120 per month	$360 per quarter	$1,368 per year

Check One: ☐ Monthly ☐ Quarterly ☐ Annually

Number of Members Covered:_____ Names of Member(s) Covered:_____

Birth Date(s) of Members Covered:_____

PAYMENT INFORMATION

Check One: ☐ Checking ☐ Savings ☐ Visa ☐ Amex ☐ Discover ☐ MasterCard

Name on Account:_____

Bank Name (Checking/Savings only)_____

Bank Routing # (Checking/Savings only)_____

Bank Account # (Checking/Savings only)_____

Credit Card # (Visa, Amex, Discover, MasterCard only)_____

Card Expiration:_____/_____Card CVN:_____/_____

Authorized Signature:_____ **Date:**_____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify AIM Health in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that AIM Health may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company so long as the transactions correspond to the terms indicated in this authorization form.